

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/17/12</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Colonial Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility is a two story fully sprinklered building determined</p>	K0000	Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>to be Type V (111) construction with a lower level located in the basement with additions and updates made prior to March 1, 2003. The facility has a fire alarm system with system wide smoke detection in the corridors, spaces open to the corridors, and in C hall first floor resident rooms which were hard wired. The facility has the capacity for 55 and had a census of 42 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered with the exception noted in K-56, and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure a door in 2 of 3 basement smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and any resident accessing the physical therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 between 2:00 p.m. and 4:25 p.m., one door in each of the two smoke barrier double door sets in the basement failed to</p>	K0021	<p>1. All fire doors reviewed and the two cited were fixed by Maintenance Director on 7/27/12.2. Maintenance Director will ensure all fire doors close properly during every Fire Drill and will document findings on the Fire Drill form. 3. Maintenance Director will log findings for each door on the Fire Drill form and fix any door not functioning properly immediately. Findings of each drill will be submitted to the Administrator to ensure compliance and kept in the Emergency Reports, Contracts, and Forms book in their office for a year.4. Administrator and Maintenance Director are responsible for ensuring fire doors close properly and will review log books weekly for 3 months, then monthly thereafter. All repairs/replacements will be reported to the IDT team in the</p>	07/27/2012			

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	close when tested twice to ensure its proper operation. The door coordinators on each door frame held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving a six inch gap. The maintenance director acknowledged at the time of observations, the coordinators were malfunctioning. 3.1-19(b)		next Quality Assurance Meeting.5. Date of Completion: 7/27/12		

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 137 of 137 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>The plan should include each type of fire extinguisher available and any special requirement for their usage. This deficient practice could affect</p>	K0048	<p>1. Fire Plan updated to include instructions for using each rating of fire extinguishers in the facility.2. If there are any changes to fire extinguisher ratings they will be updated on the Fire Plan and that information will be disseminated to the staff through monthly All-Staff Meeting. Staff will be required to sign off declaring they are aware of each fire extinguishers rating and purpose.3. Any changes to fire extinguisher ratings will be brought to the Administrator and information pertaining to the use of each fire extinguisher will be disseminated to the Staff via All-Staff Meeting monthly and fire training annually.4. The Maintenance Director is responsible for ensuring fire extinguishers are properly rated for the area of use. The Administrator is responsible for ensuring staff know how to use fire extinguishers of each rating. Training will be conducted annually on fire extinguishers and if there is a change to rating in the next All-Staff Meeting.5. Date of Completion: 8/6/12</p>	08/16/2012

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	<p>all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Alarm Procedure with the maintenance director and administrator on 07/17/12 at 4:00 p.m., the plan did not identify available fire extinguishers and address the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director and administrator acknowledged at the time of record review, these elements were not addressed in the fire plan.</p> <p>3.1-19(b)</p>				

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K0051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm systems components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether</p>	K0051	<p>1. Contractor (SafeCare) that performs fire alarm tests were contacted and made aware that an itemized list of all equipment and their findings is required each time they perform tests. They came in and provided another test and an itemized list of all equipment and functionality on 7/18/12.2. SafeCare will provide an itemized list of all equipment and functionality each time they perform their required testing. They will give that list to the Administrator for inclusion in the Emergency Reports, Contracts, and Forms book kept in the Administrator Office.3. Maintenance Director will ensure the proper form is used each time</p>	07/18/2012			

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	<p>each device passed or failed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's fire alarm system Inspection and Testing reports dated 01/24/12 and 07/11/11 with the maintenance director and administrator on 07/17/12 at 3:45 p.m., there was no itemized list of the fire alarm system components and devices such as smoke detectors, horn/strobe devices, door holder devices, and manual pull stations, with the locations and results of the visual and functional tests. The maintenance director confirmed at the time of record review, there was no itemized documentation available listing test results of all components and devices of the fire alarm system on these fire alarm inspection reports.</p> <p>3-1.19(b)</p>		<p>while escorting the contractor while the testing is in progress.4. The Administrator will ensure the proper form is delivered after each test and will include it in the Emergency Reports, Contracts, and Forms book.5. Date of Completion: 7/18/12</p>		

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K0056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide combustibile canopy sprinkler coverage for the exit discharge for 1 of 4 first floor emergency exits. NFPA 13, 1999 Edition at 5-13.8.1 requires sprinklers be installed under combustibile exterior roofs or canopies exceeding four feet in width. This deficient practice affects visitors, staff and 8 residents on A hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 at 4:30 p.m., sprinkler protection was not provided for</p>	K0056	<p>1. Quotes for completion of sprinkling the canopy at the front entrance have come in and the work has been set up to be completed within the 90 day window from the survey date.2. Any area that has a canopy over four feet in width will have sprinklers installed that connect to the overall fire system.3. Sprinklers are inspected by a private contractor who will report any system failure to the Administrator for immediate remedy.4. Failures in the system will be reported to the IDT during quarterly Quality Assurance Meeting by the Administrator with an outline of work completed.5. Date of Completion: 10/15/12</p>	10/15/2012

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	<p>the ten by thirty foot covered porch on the front of the building which serves as an exit discharge for A hall residents on the first floor. The maintenance director acknowledged at the time of observation, the porch ceiling constructed with painted plywood supported by a wood frame was not protected by sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p>				

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to provide 2 of 15 portable fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone</p>	K0064	<p>1. Fire extinguishers reviewed by contractor (Allied) and found to all be in compliance. Verification of service collars were all in place and up to date.2. Fire extinguishers are reviewed monthly by Maintenance Director as part of monthly audits and results are relayed to the Administrator and contractor to ensure all fire extinguishers have "verification of service" collars and they are up to date.3. Maintenance Director will report any fire extinguisher found to be out of compliance to the Administrator and the contractor will be called in immediately to rectify.4. Administrator responsible for ensuring all fire extinguishers are dated for their last service and are in compliance with state and federal law. Any fire extinguisher found not to be in compliance will be logged during monthly audit by Maintenance Director and reported to the Administrator for immediate fix through contractor.5. Date of Completion: 8/3/12</p>	08/03/2012

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	<p>the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, staff and 10 or more residents using the basement dining room adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 at 2:15 p.m., one ABC and K-class fire extinguisher in the kitchen each lacked a verification of service collar. The maintenance director examined the extinguishers to determine their date of manufacture but could find no stamp or other marking to verify the date. He agreed at the time of observation, there was nothing to identify when a six year service was due.</p> <p>3.1-19(b)</p>			

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K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code , Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and any resident in the basement corridor accessing the physical therapy room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 at 2:55 p.m., the laundry room had two, gas fueled dryers with no fresh air intake. The maintenance director acknowledged at the time of observation, the two gas fueled</p>	K0068	<p>1. Quotes of contractors to complete work on a ventilation system in the laundry room have been submitted and a contractor has been chosen to complete the work.2. Ventilation system will be checked by Maintenance Director weekly to ensure it is working properly and will report any negative findings to the Administrator to ensure corrective measures are taken in a timely manner.3. Maintenance Director will have the ventilation system included on his weekly rounds sheet and will submit those findings to the Administrator each week to ensure any corrective actions needed are completed.4. Weekly, monthly, and quarterly audits of all plant systems are included in the quarterly Quality Assurance Meeting and reviewed by the IDT to ensure measures are taken to provide resident safety and repairs or replacement is completed in a timely manner.5. Date of Completion: 10/15/12</p>	10/15/2012

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	dryers did not have a fresh air intake. 3.1-19(b)				

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice</p>	K9999	<p>1. Per the new law going into effect on 7/1/12 all facility resident rooms must have a smoke detector in place. Smoke detectors have been installed in all resident rooms.2. New smoke detectors have been added to quarterly rounds sheet conducted by the Maintenance Director to ensure batteries do not need to be replaced. If batteries are no longer working they will be replaced on the spot.3. Maintenance Director will keep a log of smoke detector reviews and any trends or issues will be reported to the Administrator.4. Maintenance Director is responsible for ensuring all smoke detectors are functional and have operating batteries. Maintenance Director will audit smoke detectors quarterly to ensure batteries are still working. Any batteries that need replaced will be at that time or earlier if needed.5. Date of Completion: 8/16/12</p>	08/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307		
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	<p>could affect 21 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 between 2:00 p.m. and 4:25 p.m., resident rooms on the second floor and first floor A and B halls were not provided with smoke detectors. The maintenance director said at the time of observations, he was not told to install them.</p> <p>3.1-19(ff)</p>				

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide automatic door closers on 2 of 8 doors providing access to hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas such as the kitchen, are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents using the adjacent dining room .</p> <p>Findings include:</p> <p>1. Based on observation with the maintenance director on</p>	K0029	<p>1. All facility doors opening to rooms larger than 50 square feet were reviewed and the two cited were fitted with automatic door closers.2. Doors with automatic closers added to daily rounds sheet for Maintenance Director and Weekend Manager logs. Each is to be tested and results relayed to the Administrator for immeidate fixes if required.3. Maintenance Supervisor will log findings during daily rounds and will report those findings to the Administrator. Any door not functioning properly will be fixed immediately.4. The Administrator and Maintenance Director are responsible for ensuring doors opening to rooms larger than 50 square feet have automatic door closing devices. Audits will be completed monthly to ensure all doors close properly and are fitted with devices if required.5. Date of Completion: 8/3/12</p>	08/03/2012

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	<p>07/17/12 at 1:20 p.m., the door connecting the kitchen to the dining room stood wide open. It had no self closer. The maintenance director said at the time of observation he was unaware the door required one.</p> <p>2. Based on observation with the maintenance director on 07/17/12 at 1:50 p.m., the door connecting the 80 square foot storage room to the conference room had no self closer. The room was used for storage of supplies in cardboard cartons, plastic and paper wrapping. The maintenance director said at the time of observation, he was unaware the door required a self closer.</p> <p>3.1-19(b)</p>			

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations, was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect 4 or more staff, visitors, and any resident</p>	K0143	<p>1. Outlet and electrical light switch raised above 60 inches in oxygen room.2. Oxygen room will be reviewed monthly to ensure there are no electrical outlets or components below 60 inches from the floor. If found out of compliance they will be corrected on the spot.3. Maintenance Director will audit oxygen room as part of monthly plant reviews and ensure there are no outlets or electrical components within 60 inches of the floor. If it is found that something is not in compliance it will be rectified on the spot. Findings of monthly audits are given to the Administrator for follow up and any safety concerns are relayed to the IDT during quarterly Quality Assurance Meeting.4. Maintenance Director and Administrator are responsible</p>	08/16/2012

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	<p>accessing the nearby physical therapy department.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/17/12 at 1:10 p.m., the oxygen storage room had three 181 liter capacity liquid oxygen storage tanks stored in the room, identified as the oxygen transfer room. One electrical light switch and one electrical outlet were each measured at 46 inches above the floor. The maintenance director acknowledged at the time of observation, the electrical switch and outlet were less than the five feet permitted.</p> <p>3.1-19(b)</p>		<p>for ensuring no electrical component is within 60 inches of the floor in the oxygen room and will review monthly audits of oxygen room with IDT during Quality Assurance Meeting quarterly.5. Date of Completion: 8/16/12</p>		